MEDICAL STATEMENT
FOR
PARTICIPANTS WITH ALLERGIES/CHRONIC DISEASES

Other medical personnel may complete this form (dietitian, speech pathologist, occupational therapist), but a physician must sign in agreement as to what is written. For purposes of this program, a 'recognized medical authority' means a licensed physician, nurse or physician's assistant.

Name of Participant	**Age**
Parent Name	***Telephone***

Agency	
Site	***Telephone***

Food Allergy/Chronic Disease:

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Diet Prescription and/or Texture Modification: (*Please describe in detail to ensure proper implementation and compliance.)*

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Indicate texture: ❒ Regular ❒ Chopped ❒ Ground ❒ Pureed

Foods to be Omitted and Substitutions: *(Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach a sheet with additional information.)*

Foods to be Omitted	Suggested Substitutions

Signature of Preparer	**Printed Name**	**Telephone** ( )	**Date**
Signature of Recognized Medical Authority	**Printed Name**	**Telephone** ( )	**Date**